
The medical student and the suicidal patient

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Abstract

Today's medical students are being confronted with ethical situations of far greater complexity than were their predecessors and yet the medical education system does little to prepare students for the ethical dilemmas which they inevitably face when entering the hospital environment. The following article addresses the issues surrounding a case where a patient has told a student in confidence of his plans to commit suicide. What should the student do? The only way for the student to prevent death is by breaking confidentiality because the student has insufficient clinical experience to provide adequate guidance. However, this requires ignoring the patient's right to autonomy, a right enshrined in both case law and medical ethics. Clearly the student's ethical, moral and legal position must be carefully evaluated.

Case scenario

As a medical student, you have been seeing an in-patient for follow-up as part of a case study required by the faculty. The patient has been in hospital for three weeks recovering from extensive burns. You have developed quite a close patient-medical student relationship because you have been the only person in the medical team to see him daily.

During a conversation just prior to discharge, the patient asks whether he may tell you something highly confidential which must never be repeated. He states that if questioned, he will deny ever speaking to you. You agree and the patient proceeds to tell you that his so-called accident was actually a suicide attempt. He is distraught because his long-term relationship recently broke up and he says that he intends to shoot himself upon release from hospital.

Introduction

Today's medical students are being confronted with ethical situations of far greater complexity than ever their predecessors faced. Recent challenges relate to the younger population of this country. The last decade saw the introduction of HIV/AIDS into

Australia and the rise of suicide to become the leading cause of death of male youths in rural New South Wales.¹ The medical education system of today does not adequately prepare students for the ethical dilemmas which they inevitably face when entering the hospital environment. It is the natural tendency of any person, and in particular of a member of the medical profession, to seek to save, rather than to abet the ending of, a human life. In this case a patient has told a student, in confidence, of his plans to commit suicide. The only way for the student to prevent death is by breaking confidentiality, because the student has insufficient clinical experience to provide adequate guidance. However, this course of action involves ignoring the patient's right to autonomy, a right enshrined in both case law and medical ethics. Clearly the ethical, moral and legal position that the student is in must be carefully evaluated.

The student's immediate concerns

By confiding in the student, the patient places the burden of decision-making upon him or her. The only reason the patient can possibly have for doing this, is that he wants the student's *help*. After realising this, the student has several immediate concerns. First, the patient is "... just prior to discharge ..." hence any decision regarding confidentiality must be reached quickly. Furthermore the student *cannot leave* the patient in case he is discharged and commits suicide. The student must also evaluate the patient's sincerity regarding his proposed suicide attempt. The patient has already received extensive burns from a previous suicide attempt, demonstrating that he was of sufficient determination, at one time, to attempt to end his life. Hence the patient's contention that "... he intends to shoot himself ..." should be regarded as being sincere. Additionally, many patients commit suicide after burn injuries due to their altered appearance, which places this patient in a high-risk group for suicide.² On the other hand, attempted suicide by burning is often construed as attention-seeking behaviour and in this case could well have been an example of such behaviour directed towards the patient's long-term partner as a demonstration of the depth of his feeling and an attempt to recommence the relationship, providing further evidence to the student that the patient is requesting help.²

Key words

Suicide; medical ethics; medical students.

Unfortunately, the student has promised the patient that his confidence will be maintained. How can the student ignore this explicit request for confidence and prevent the patient from doing what he desires? It is this conflict between the patient's right to choose his own destiny, the duty of confidentiality and the duty of care owed to a patient that creates the ethical dilemma for the student.

Ethical and moral concerns of the student

DUTY OF CONFIDENTIALITY

Confidentiality and its importance in the patient-doctor relationship have always been highly stressed by the medical profession. It is also a well established principle that the law will uphold the sanctity of information imparted to another in confidence.^{3 4} Whilst the notion of confidentiality has grown out of the Hippocratic Oath, Sir Thomas Browne succinctly stated the importance of confidentiality to the doctor-to-be: "Think not Silence the wisdom of Fools, but, if rightly timed, the honour of wise Men . . .".⁵

The student's duty of confidentiality is contingent upon his or her role as a member of a medical team. Without the team, the student is only an acquaintance and would not have gained access to any information about the patient. The duty not to divulge information is a burden shared by the team and information gained by one member of the team is ordinarily shared with other members of the team. In this case however, the patient has specifically requested that the student not share the information, a request that the student should comply with until he or she has considered the implications of the situation, unless the patient's departure from hospital is imminent.

There are, however, situations in which silence, which is a cornerstone in the clinical relationship, should not take precedence over the duty to care for the patient. This is exemplified by the Declaration of Hawaii, section 9:⁶ "Whatever . . . has been told by the patient, or has been noted during examination or treatment, must be kept confidential unless . . . to prevent serious harm to self or others makes disclosure necessary."

The Declaration of Hawaii, in conjunction with the principles of the duty to care described below, clearly indicate that the duty to care for a patient is, in some circumstances, more important than keeping that patient's confidence, particularly if the patient is contemplating causing harm to himself.

Prior to 1983, suicide was an offence in New South Wales, Australia and hence there was no dilemma faced by the doctor or student breaking confidentiality to prevent a suicide. Section 574B of The Crimes Act, 1900, No 40; Crimes (Mental Disorders) Amendment Act (1983) (henceforth known as "the Crimes act") states: "Prevention of Suicide: It shall be lawful for a person to use such

force as may reasonably be necessary to prevent the suicide of another person . . .".⁷

The student cannot prevent the patient from leaving hospital by himself and therefore, the only force that the student has at his disposal is to break confidentiality. There have been several cases in the USA which provide specific examples of how confidentiality may be broken for the good of the patient. Although these cases are not binding on Australian courts, there is no reason to believe that these decisions would not be applied here if the situation arose.⁸⁹ *Tarasoff v Regents of the University of California*,¹⁰ conducted in 1974, provided a precedent for the right of potential homicide victims to be warned. This case involved a patient telling his psychiatrist that he intended to murder his ex-girlfriend. The physician informed the police of his intent, but failed to warn the intended victim and was held liable. Although this case concerned homicide, its conclusions can be applied to notifying others of a potentially suicidal patient's intended actions [see also *Hedlund v Orange County*].¹¹ In the case of *Bouvia v County of Riverside*¹³ a patient declared herself suicidal upon admission to a psychiatric institution in California in 1983 and asked staff not to hinder her attempt. The court ruled that the requirement for the common good overrode respect for her autonomy, concluding that ". . . society's interest in preserving life and the medical profession's obligation to do so outweighed her right to self-determination".¹³

If the student refrained from taking action (breaking confidentiality) then this is a contributing factor in the death of the patient and the student cannot escape responsibility because the patient's actions amounted to the cause of death.¹⁴ This stems from section 31C of the Crimes act which states that: "... a person who aids or abets the suicide or attempted suicide of another person shall be held liable . . .".¹⁵

By not taking action, the student would have facilitated the suicide and hence would be liable for abetting that act and be found negligent according to the principles of *Bolam v Friern Hospital Management Committee*:¹⁶ "Negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do . . .".

RIGHT TO AUTONOMY

A patient has, in most cases, the right to refuse treatment and to choose for himself a course of action that he deems to be appropriate.⁶¹⁷ In Australian society, the right of an individual to make his own decision is paramount and has received prominent attention in medico-legal cases where negligence has been proven due to a lack of informed consent (for example *Rogers v Whitaker*,¹⁸ where the doctor neglected to give details of an extremely rare condition to a patient who

later developed such a condition as a result of the operation). This position is reiterated in the case of *Re T (adult: refusal of medical treatment)*,¹⁹ in which Staughton, L declared (at 668) that: "An adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical treatment . . .".²⁰ Important in the latter case, is the notion that the patient must have a ". . . mental capacity (which) is unimpaired . . .". This provides further ethical and legal direction to the student in making her decision regarding confidentiality, for the right of the patient to make decisions on what course of action he should follow is limited, as is the duty of confidentiality, by the competence of the patient in arriving at that decision.

DUTY OF CARE

The student is bound by two principles. The first is to cause no harm – *primum non nocere* – when entering the medical profession a student intuitively understands that this is the pinnacle of the clinical relationship. Hence the student cannot act in such a manner as to cause the patient harm, either through the student's actions or his failure to perform such actions as may be necessary in the circumstances.¹⁷ According to the principle of beneficence, the student must act in the best interests of the patient, including the making of decisions (if the student is able to make those decisions) on behalf of a patient who is incapable of making autonomous decisions.¹⁷

There is no general rule in cases of suicide regarding the precautions that must occur to provide adequate care for the patient, provided that the defendants have been found to have exercised reasonable care.^{21,22,23} For a doctor, this duty has a clear basis in law,²⁴ however the same is not true for the student. A student cannot care for the patient because he does not have the experience to provide adequate care. The student may, however, play a role in that care as part of a team and hence it is as a member of the team rather than as an individual member of the medical profession that the student owes a duty of care to the patient. The student also owes a duty of care as a fellow member of society. By way of example, in the case of *Russell*,²⁵ the defendant stood by whilst his wife drowned herself and their two children. Macarthur, J²⁶ concluded that ". . . a duty to care for others is more rationally based on their inability to care for themselves, than on (a) formal bond . . .". Hence, although the student does not have a formal bond with the patient in the form of a contract, as exists between doctor and patient, the student has a duty of care imposed upon him by the patient's inability to make rational decisions.

MORAL ISSUES

Modern medical morals view suicide as being neither right nor wrong as an act in itself, with the patient

being free to choose his time and place of death, if he is capable of doing so. This is similar to the view expressed late last century by David Hume, who considered suicide a part of God's plan and order, stating that "Suicide is not necessarily against the agent's interests. Misery, sickness, and misfortune can make life not worth living."²⁷ A contrasting viewpoint was offered in the middle of the 18th century by Kant, who in suggesting that suicide is logically self-defeating, appealed to the inherent inconsistency of the act, rather than its unnaturalness, stating that ". . . we cannot attempt to improve our lot – escaping pain, misery and despair – by destroying ourselves altogether . . .".²⁷ Rather than concentrating upon a comparison of the "good" of life, with the moral value of suicide, the important moral issue for the student in today's society is the question of intervention.⁶ Thus the dilemma facing students is not whether suicide is morally justifiable, but rather whether measures taken to intervene are justifiable.

To intervene or not?

Only one of two decisions can be reached when a patient is potentially suicidal: to break confidentiality, thereby intervening in the patient's intended action; or to retain the patient's confidence and allow that patient to make his own choice regarding the value of his life.¹⁷ The decision that is made depends upon the circumstances surrounding the potential suicide. If the patient has reached his decision rationally, then the student would not intervene. Conversely, should the patient reach his decision as the result of an irrational process, as for example, is the case with many psychiatrically ill patients, then the decision to intervene must be taken. Hence the patient's capacity for rational judgment is crucial to the decision-making process. It must be remembered that non-intervention means that although the patient will be allowed to choose his own destiny, help in committing the act will not be forthcoming.

An important consideration for the student is the ability of the patient to make sound judgments regarding his future actions. The student must therefore examine the reasons that this patient has given for his suicidal ideation. The patient stated that he "... is distraught because his long-term relationship recently broke up ...". The traumatic nature of his injuries and altered appearance are further factors that contribute to the patient's state of mind. All these factors affect his judgment, thereby reducing his capacity for rational decision-making. Hence ethically, and in good conscience, the student must intervene in the patient's proposed suicide even though in doing so, confidentiality will be broken.

What happens though if there is not enough time for the student to consider all of these factors, for example, if the patient was "... just prior to discharge ..."? The only decision that can be made in this situation, is for the student to intervene and risk

Table 1 Summary of the arguments for and against intervention in the case of a potentially suicidal patient [adapted from Bloch and Chodoff (1991)].⁶

Intervention	Examination
<p>Taking the patient's decision as irrational, impulsive, distorted by mental illness.</p> <p>On the assumption that his decision is reversible, certain steps, which are also reversible, are taken to prolong his life.</p> <p>Paternalism: forcing the patient to act rationally as an expression of care for his real interests.</p> <p>Care for the patient's family, who usually ask for an intervention.</p> <p><i>The price:</i> forcing him to act against his will, prolongation of his mental and physical misery, serious loss of liberty.</p> <p><i>Underlying assumption:</i> the instinctive drive to save other people's lives plus the professional duty and practice of doctors to do so.</p>	<p>Taking the patient's decision as authentic, deliberate, clear-headed and rational.</p> <p>On the assumption that his decision is irreversible, no steps are taken, thus irreversibly letting him commit suicide.</p> <p>Respect for the patient's autonomy and liberty to kill himself as to take any other decision, even if it seems irrational to us.</p> <p>Taking the patient's side, rather than that of his family. Priority of his, rather than his family's interests.</p> <p><i>The price:</i> missed opportunities, the infinite loss involved in death, the possibility of the most "tragic mistake".</p> <p><i>Underlying assumption:</i> "...nothing in life is as much under the direct jurisdiction of each individual as are his own person and life" (Schopenhauer).²⁸</p>

breaking confidentiality unnecessarily. Intervention in a potential suicide (and thereby preventing it – hopefully) is completely reversible should subsequent events prove that the decision to intervene was incorrect. Non-intervention is a far more risky decision, for should the patient commit suicide and subsequent events demonstrate that the patient's judgment was distorted, then a tragic and avoidable death will have occurred. For this reason, on the question of whether to intervene the student should err on the side of caution and if there is any doubt as to the patient's ability for rational thought (particularly if the student is not qualified to make such a decision), or time is too short to make this decision, then intervention is the only acceptable course of action.

What should the student do?

It is clear from the arguments presented above that morally, legally and ethically the student must break the patient's confidentiality and discuss the patient's statement with the consultant who is responsible for the patient. In cases of attempted suicide, a patient will often reach out to many people, allowing each to believe that he alone knows of the patient's plans and hence the student should ask the patient if he has told anyone else of his plans. This has important repercussions for the question of confidentiality, because if the patient has told others then discussing the case with those people would *not* betray the patient's confidence.

The student must be completely honest with the patient and explain to him that what he has already stated threatens confidentiality. The patient must, before any further action is taken, be asked to consider whether he will discuss his feelings with anyone else, or if he will consent to the student conveying those feelings to an experienced doctor. Crucial to this matter is an indication from the student that he cannot offer adequate assistance to the patient. This stems from case law decisions which found that the patient is entitled to the level of care equivalent to the qualifications that the doctor possesses.²⁹

Should consent be given, the student can discuss the case with an experienced physician without confidentiality becoming an issue. Should, however, consent be withheld, then the student, as a member of society, owes a duty of care to the patient to "... use such force as may reasonably be deemed necessary to prevent the suicide ..." and thus the student must break confidentiality. Care should be taken to ensure that the physician in charge appreciates the circumstances under which the attempted suicide was discussed and particularly whether the patient has consented to the breaking of confidentiality. The student must also tell the patient that his confidence has been broken, not to do this would be a further breach of trust.

Possible negligence of the physician in charge of the patient

This patient is in a burns unit that contains people who are physically scarred for life, an alteration to their appearance and self esteem which often leads to suicide.^{2 30 31} A "reasonable physician" who is a consultant in a burns unit should be able to foresee the likelihood of suicide in a patient.^{16 32} Hence the consultant would be considered negligent, not because of the failure to diagnose the suicidal intent due to the break-up of the patient's relationship, but for his failure to foresee the possibility of suicide after such trauma.

Conclusion

From an ethical, legal and moral perspective, the student is justified in limiting confidentiality to prevent a suicide. To see this, the relative obligations of the duties of care and confidentiality and the patient's right to autonomy, as well as the law, must be carefully evaluated. When they are the student can be seen to owe a duty of care to the patient as a citizen and as a member of the medical team. It is important to remember that the duty of confidentiality and the patient's right to autonomy are limited by his capacity for sound judgment, making this issue

crucial. The patient is requesting help from the student by telling him about his suicidal tendency, a tendency derived from the patient's misfortune, rather than any rational decision-making process. This plea must not be ignored or the student and the rest of the team would be found negligent in the delivery of care for that patient. Hence the student can make only one choice – to tell.

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News and notes

Legal and Ethical Aspects of Caring for the Vulnerable Patient

A medico-legal study day on the legal and ethical aspects of caring for the vulnerable patient will be held at Wolfson College, Oxford on Tuesday 18th of November 1997.

The course organiser is Dr Sara Booth, NHS R&D Fellow and Honorary Consultant Physician, Churchill Hospital, Oxford.

Contributors will include: Mr Denzil Lush, Master

of the High Court of Protection, Dr Robin Jacoby, Clinical Reader, Department of Psycho-geriatrics, Churchill Hospital, Oxford University and Dr Tony Hope, Director of ETHOX, The Institute for Ethics and Communication in Health Care Practice.

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